ANNUAL PAIMI ADVISORY COUNCIL REPORT (ACR) [42 CFR 51.23 (a)(3)]

Fiscal Year:	2004
State:	Virginia
Name of P&A System:	Virginia Office for Protection and Advocacy
Report Prepared By: (Advisory Council Chair)	Chris Harrison
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Date Submitted:	12/29/2004
Signature of PAIMI Chair	

SECTION A.

POSITION OF ADVISORY COUNCIL as of SEPTEMBER 30, of this year

A.1. Status: Total members on the Advisory Council.

Primary ID*	Total #
a. Number of Advisory Council Members Serving on 9/30	13
b. Recipients/Former Recipients (R/FR) of mental health services*	6
c. Parents/Family Members of R/FR of mental health services*	3
d. Mental health service providers*	
e. Mental health professionals*	2
f. Attorneys*	2
g. Individuals from the public knowledgeable about mental illness*	
h. Others (please identify). _____	
i. Vacancies as of 9/30 [Please identify each vacant position].	2-8
j. **Total Number of seats on the PAIMI AC****	15-20

A.2. Ethnicity/Race of PAIMI Advisory Council members

Ethnicity/Race	Number of Members
American Indian / Alaskan Native	
Asian	
Black /African American	
Hispanic/ Latino	
Native Hawaiian/Other Pacific Islander	
White	13
Vacancies as of 9/30	2-8
Total: 15-20	

A.3. Gender	
Male: 5	**Female:** 8
TOTAL: 13	

A.4. Does the P&A system have a multi-member governing board?	Yes
a. Total number of governing board members	11
b. Is the Chair of the PAIMI Advisory Council a member of the governing board? Yes, however, the PAIMI Advisory Council Chair is not a voting member	
c. Do any other PAIMI Advisory Council members hold seats on the Governing Board? No	

SECTION B. ADVISORY COUNCIL ACTIVITIES See PAIMI Act at 10805(7)

B.1.	Advisory Council
Term of Appointment (Number of years)	4
Number of Terms a Member Can Serve	1
Frequency of Meetings	quarterly
Number of Meetings Held in the Fiscal Year [42 CFR 51.23(b)(3) requires a minimum of 3]	4
% (Average) of Advisory Council Members Present at Meetings	67%

B.2. Are P&A Program staff invited to attend the PAIMI Advisory Council meetings?

Yes X; identify the positions of staff usually invited to attend:
The Executive Director
The Policy Director
Administrative Assistant (Outreach Advocate)
Advocates/Attorneys routinely provide legal rights training at each meeting.

B.3. Are any governing board members invited to attend the PAIMI Advisory Council Meeting?

Yes—In FY04 the Board Chair made a point to remind and encourage Board members (at each Board meeting) to attend the scheduled Advisory Councils meetings.

B.4. Did the council work jointly with the governing authority or board* to develop the annual PAIMI priorities and priorities? [42 CFR 51.23(a)(2)]*

Yes
The Council was a major contributor to VOPA and Governing Board's effort in the development of the annual priorities. The Governing Board directed VOPA to continue the FY04 goals and focus areas for FY05 in order to do a more intentional planning process for FY06. The objectives for each goal/focus area however were to be updated.

The Council was involved in identifying participants and groups to be represented in targeted focus groups for public comment. In addition, the Council participated in a mock focus group in order to provide the VOPA staff with feedback about the process as well as to provide input into the development of the objectives. Several of the Council's recommendations were included in the objectives.

B.5. Did Council members attend any *in-State or out-of- State* training or educational presentations related to PAIMI Program activities? [42 CFR 51.27* optional for Advisory Council and Governing board members].

The Virginia Office for Protection and Advocacy provides legal rights and disability related training at every Council meeting.

In addition, Council members are very active in the mental health community and attend functions both in and out of state. Please see the list below for activities that Council members were involved in.

National Mental Health Association; Long Beach CA
"Model for Policy Training"

Crisis Intervention Team Training: Memphis TN

Virginia Activities:
Mental Health Planning Council
Olmstead Oversight Advisory Task Force
Virginia Trial Lawyers Association
Mental Health Association Board (member)
Partnerships for Access to Healthcare Taskforce
Consumer Empowerment and Leadership Training
Volunteer at State Mental Health Institution
Local and State Human Rights Committee Seminar
Local Human Rights Committee (officer/member)
Local Human Rights Committee interview panel member for state mental health institution
Advocate position
Focus group member to address recovery and ways to improve mental health. The results were sent to the DMHMRSAS Commissioner.
State Board of Mental Health
Northern Virginia Mental Health Consumers Association
Director of the DMHMRSAS Office of Human Rights is an active member of the PAIMI Advisory Council

B.6. Does the P&A system have established written policies and procedures for reimbursing advisory council members for expenses?

PAIMI Advisory Council members are reimbursed for their Council activities in accordance with the travel reimbursement policies for State employees.

B.7.Were Advisory Council members reimbursed for expenses incurred for PAIMI Program related activities? Yes **If so, complete the following chart.**

B.7.a. Reimbursement of Expenses

Activity	# Attending	P&A	Self	Other
Council Meeting (11/03)	9			
Council Meeting (2/04)	10			
Council Meeting (5/04)	9			
Council Meeting (8/04)	7			
Board Meetings	1 Council Member (Chair)			

B.8. Was the Advisory Council* provided with reports, materials, and fiscal data that enabled them to review the following P&A activities:

a. Existing program policies, priorities, and performance outcomes. Yes

b. If yes, did the submissions include the following information:

1. At least an annual report on expenditures for the past two (2) years.

No

VOPA, is a state agency and because of having several funding streams, has a very complicated accounting system that is difficult to explain and to understand. VOPA staff have been working diligently with the Governing Board of Directors to develop fiscal reports and tools that accurately reflect fiscal activities and yet are understandable for lay people. We have made progress, but the State fiscal system requirements are not readily understood.

The PAIMI Advisory Council Chair attends the Board meeting where the fiscal reports are reviewed and discussed.

VOPA is working on developing simpler fiscal tools for the Board and will share with the Council as soon as we find something that works.

2. Projected expenses for the next fiscal year identified by budget category.

No, please see above.

B.9. Completion of this section is OPTIONAL. However, if you choose to respond, please describe any other PAIMI Advisory activities, other than council meetings, as listed below:

Special Projects

The Council members helped with recruitment of new Council members. They provided resources of contacts and organizations to approach. They also helped to distribute recruitment flyers and Council Interest Surveys.

At every Governing Board meeting the PAIMI Advisory Council Chair gives a verbal report of the Council's activities since the last Board meeting. This report is usually a review of the

Council meeting and what impact it may have had on the members' other advocacy efforts in the mental health community.

Council Chairs are given the opportunity to serve on the Governing Board committees. However, geographic barriers, work schedules and Virginia Freedom of Information Act restrictions have limited their direct involvement. Council Chairs and VOPA staff update the council members on the Governing Board committee work.

SECTION C. ADVISORY COUNCIL ASSESSMENT OF PAIMI OPERATIONS

Goal 1: People with Disabilities are Free from Abuse and Neglect
Focus Area #1: Inappropriate medication in Mental Health Institutions Objective #1: Conduct one patient training at each state mental health institution to inform patients of their rights concerning medication.
For each indicator of success, provide the following information: a. Focus #1 Objective #1 b. Objective was: Met c. Base Measure used to determine whether priority was met: 9 institutions d. Target population: patients of mental health institutions in Virginia e. Outcome: patients of 9 mental health institutions in Virginia who participated in the training received information about their rights concerning medication
Virginia Office for Protection and Advocacy (VOPA) staff presented at least one training session at each of the nine (9) state mental health institutions. Training included patient rights concerning medication and the right to informed consent. Following presentations, several patients requested and were provided additional information and technical assistance, including detailed information concerning the role of a legally authorized representative (LAR) and court-ordered treatment in the context of a medication/informed consent issue, better equipping patients for self-advocacy or otherwise resulting in VOPA case level services as needed. In addition, pursuant to a federal court settlement, the VOPA provided quarterly rights training for patients in the Department of Veterans Affairs Hospital in Richmond, Virginia.

Goal 1: People with Disabilities are Free from Abuse and Neglect
Focus Area 1: Inappropriate Medication in Mental Health Institutions Objective #2: Investigate ten (10) complaints from patients of mental health institutions where there is probable cause to believe that medication is administered without informed consent. If violations are found, represent the patients to prevent continued violation of the residents' rights.
For each indicator of success, provide the following information: a. Focus #1 Objective #2 b. Objective was: Met c. Base Measure used to determine whether priority was met: 10 complaints d. Target population: patients of mental health institutions in Virginia e. Outcome: systemic reform

VOPA staff completed fourteen (14) investigations of allegations of medication without informed consent. In one case, a patient of a state mental health institution complained to a VOPA staff, who was on-site at the institution, that the patient was being forced to take psychotropic medications against her will. After obtaining consent to review the patient's records, VOPA immediately reviewed the record and concluded that the patient was being medicated without informed consent. VOPA presented the issue to the patient's doctor and the involuntary medication ceased. In another case, VOPA successfully advocated for appointment of a legally authorized representative and further assured that medication decisions were made only after full explanation to the authorized representative and receipt of the authorized representative's decision. Finally, in two cases, VOPA obtained agreements from two separate state mental health institutions to implement comprehensive staff training to assure full understanding and implementation of informed consent requirements. This systemic reform favorably impacts an on-going average census of 240 patients.

In addition, VOPA has achieved reversal of decisions to medicate based on alleged "emergency exceptions" to the informed consent requirements; an alleged routine practice used to order medications "just in case" an individual may need them. This allowed ward staff to administer the emergency medications without obtaining informed consent. Besides reversal of specific, inappropriate "emergency exceptions," one institution instructed all medical staff regarding criteria for administration of medication under the emergency exception ("risk of significant deterioration" is not adequate, but risk of substantial property damage" is. This systemic reform favorably affects an ongoing average census of 100 patients.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area 2: Staff on Patient Assaults in State Mental Health Institutions
Objective #1: Review all Critical Incident Reports submitted by State Mental Health Institutions.

For each indicator of success, provide the following information:

a. Focus #2 Objective # 1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: VOPA staff read each Critical Incident Report (CIR) that is submitted by the state institutions. There is not a known number to establish a base measure.
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: All CIR were read and entered into a database.

By statute, VOPA receives Critical Incident Reports (CIR) submitted by the mental health institutions. Every CIR is read by VOPA staff and pertinent information is entered into a database. All CIR that involve injuries within current program priorities and other alarming or unusual reports are identified and further reviewed. In addition, the VOPA Executive Director conducts a weekly meeting to address the reports, their implications, and remedial action.

In conjunction with VOPA's review of CIR, VOPA routinely requests that the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) produce internal investigation reports and supporting materials. Early in the fiscal year, DMHMRSAS began broad and inappropriate redaction of internal investigation reports that had previously been provided without redacting. VOPA objected on legal grounds and inappropriate redaction of the internal investigation reports ended.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #2: Staff on Patient Assaults in State Mental Health Institutions
Objective #2: Conduct preliminary inquiries of Critical Incident Reports that involve alleged staff on patient assaults resulting in serious bodily injury or loss of consciousness requiring medical treatment.

For each indicator of success, provide the following information:

a. Focus #2 Objective # 2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the content of the reports received.
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: systemic reform

Five preliminary inquiries related to Critical Incident Reports or other complaints from state mental health institutions have been completed. Based on the preliminary inquiry results, four investigations have been opened and completed. In one case, a patient was strip searched in a manner that violated the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services' Human Rights Regulations. As a result of VOPA's inquiry and investigation, the institution initiated and has implemented broad-based reforms, including changes to the search policies and procedures (which changes were designed to increase patient safety and protect patient dignity and rights), the addition of specific policy provisions addressing body cavity searches, new required trainings for all direct care nursing staff and security personnel (at least 70 such employees have been trained to date), and the establishment of annual nursing "Competencies" which require direct care nursing staff to demonstrate a working knowledge of the patient search criteria and procedures each year, as a condition of their employment. This systemic reform favorably affects an average census of 100 patients.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #2: Staff on Patient Assaults in State Mental Health Institutions
Objective #3: Conduct full investigations of five (5) Critical Incident Reports identified in #2 above that are selected for preliminary inquiry where there is probable cause to believe that abuse or neglect occurred. If violations are found, take appropriate action.

For each indicator of success, provide the following information:

a. Focus # 2 Objective # 3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 5 investigations
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: systemic reform

The objective to conduct full investigations of five (5) CIR includes investigation of reports from both state mental health and state mental retardation institutions. A total of six investigations of such reports and complaints were completed, four of which involved mental health facilities. See narrative for goal 1, focus area 2, objective 2 above.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #2: Staff on Patient Assaults in State Mental Health Institutions
Objective #4: Conduct quarterly trend analyses to determine whether staff on patient assault is more prevalent at specific mental health institutions and, if so, conduct systemic investigations of such institution. If violations are found, take action to reduce such violations.

For each indicator of success, provide the following information:

a. Focus #2 Objective # 4
b. Objective was: Met
c. Base Measure used to determine whether priority was met: Quarterly trend analyses
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome quarterly trend analysis conducted

VOPA conducts quarterly trend analyses of Critical Incident Reports received from state institutions. The trend analyses address a wide variety of potential trends, including type of injury, location of injury, time of day and day of the week, staffing, and other areas. Trend analyses are continuing and are being refined to account for variations, including the number of patients in one institution compared to the number in another institution, and other potential variables to assure accurate comparisons of trends between the various institutions. The VOPA Executive Director conducts a weekly meeting with strategic VOPA staff to discuss CIR, their implications, quarterly trend analyses and potential remedial actions.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #3: Abuse and Neglect in Community Settings
Objective #1: Investigate five (5) instances of alleged abuse and neglect in community settings that are licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services that involve serious bodily injury or loss of consciousness requiring medical treatment where there is probable cause to believe that such abuse or neglect occurred, or where there was inappropriate use of seclusion or restraint, and take appropriate action.

For each indicator of success, provide the following information:

a. Focus #3 Objective # 1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 5 investigations
d. Target population: PAIMI eligible individuals receiving services in community settings licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services
e. Outcome: 10 investigations have been completed

VOPA has worked on 14 investigations and 10 have been completed with follow-up action where abuse or neglect was found. They included private psychiatric facilities, a group home, an assisted living facility, a school, and a nursing home.

In one investigation, VOPA's investigation uncovered theft of prescription medications, physical abuse, and neglect of an individual's medical needs who later died, and false entries in medical records. VOPA has filed suit for an injunction against further abuse and neglect. The litigation is ongoing. This facility is licensed for 41 beds. If the litigation is successful, the result will be systemic in nature, both to the subject facility and hundreds of similar facilities in Virginia.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #1: Inform Juvenile facilities of VOPA's authority and objectives.

For each indicator of success, provide the following information:

a. Focus #4 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 1 mailing to 140 providers
d. Target population: PAIMI eligible individuals in juvenile detention facilities and schools
e. Outcome: Participants in training sessions at the Summit received information about disability rights.

VOPA completed a mailing to juvenile facilities that included clarification of VOPA's right to access.

VOPA participated in the Parent Educational Advocacy Training Center workgroup that planned a Juvenile Justice Summit in May 2004. VOPA staff presented on challenges facing children in Juvenile Justice facilities. Specifically, VOPA discussed the rights such children have to receive transition planning and vocational training.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #2: Conduct preliminary inquiries of complaints that allege inappropriate restraint use in juvenile facilities and schools that result in serious bodily injury or loss of consciousness requiring medical treatment.

For each indicator of success, provide the following information:

a. Focus #4 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as VOPA conducted preliminary inquiries on every complaint received.
d. Target population: PAIMI eligible individuals in juvenile detention facilities and schools
e. Outcome: systemic reform

VOPA conducted a preliminary inquiry of a complaint alleging inappropriate seclusion of an adolescent patient in a Psychiatric Residential Treatment Facility (PRTF). As a result of the preliminary inquiry, a full investigation was opened. For results see Goal 1, Focus Area 4, Objective 3 below.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #3: Investigate five (5) instances of such allegations where there is probable cause to believe that abuse or neglect occurred. If abuse or neglect is found, report findings.

For each indicator of success, provide the following information:

a. Focus #4 Objective # 3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 5 investigations
d. Target population: PAIMI eligible individuals in juvenile detention facilities and schools
e. Outcome: systemic reform

VOPA conducted a full investigation of a complaint of inappropriate seclusion of an adolescent patient in a Psychiatric Residential Treatment Facility (PRTF). The investigation revealed that, while the time spent in seclusion was not excessive given the applicable regulations and the child's dangerous behavior toward others, the lack of active treatment provided during seclusion was inappropriate. As a result of VOPA's investigation and demand for change, the PRTF revised its policies to include a requirement for active treatment during extended periods of seclusion, a requirement for documentation of the active treatment provided, and a requirement for training on ways to decrease the use of seclusion and restraint and the provision of active treatment.

In a separate investigation, VOPA investigated allegations of inappropriate restraint of students at a private school serving students with mental illness. The investigation confirmed the inappropriate restraint and the school agreed to systemic reform, including termination of employees who engaged in inappropriate restraint and adoption of a new restraint procedure that places greater emphasis on verbal de-escalation.

In another investigation, several employees of the Department of Medical Assistance Services, Department of Social Services, and DMHMRSAS reported recurring instances of possible abuse at a facility in Leesburg. VOPA collected multiple records of complaints against the facility and contacted individuals mentioned in those records. VOPA also contacted management and staff as well as the Fairfax County Police. VOPA successfully facilitated the transfer of two individual minor clients from the facility to a residential school. VOPA attempted to work in conjunction with Child Protective Services and the Police to investigate the facility with greater scrutiny. After our initial inquiries, the facility was sold to a new entity and restructured.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #4: Identify two (2) schools that subject children with disabilities to in-school suspensions, "time-outs" and other restraints and do not provide those children with appropriate Positive Behavioral Supports and Interventions. Initiate litigation and/or other advocacy to change this practice.

For each indicator of success, provide the following information:

a. Focus #4 Objective # 4
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 2 schools
d. Target population: PAIMI eligible individuals in schools
e. Outcome: systemic reform

VOPA has completed one investigation of a school and is conducting another. In the first, an elementary school refused to provide positive behavioral support and services for a child prior to engaging in disciplinary actions. VOPA first obtained a favorable resolution for the child and then investigated the way the school acted in similar cases. VOPA demanded that the school receive specific training to avoid further improper disciplinary actions. The school agreed and has already received the training. In the other case, a school sought to expel a child and insisted that, despite his disabilities, the child was not eligible for special education. VOPA first represented the child and successfully advocated for him to be found eligible for special education, resulting in the child not being expelled. VOPA then investigated the school and found that its special education determinations were based on flawed and illegal methods. As a result, it is possible that several students were improperly disciplined because they were not found eligible for special education. VOPA is currently advocating, and will take more aggressive steps if necessary, to ensure that the school and district properly consider children's disabilities during disciplinary procedures.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #5: Determine from review of available data whether there is extensive use of physical restraints in public schools.

For each indicator of success, provide the following information:

a. Focus #4 Objective #5
b. Objective was: Met
c. Base Measure used to determine whether priority was met: review was completed
d. Target population: PAIMI eligible individuals in public schools
e. Outcome: working for systemic reform

VOPA has researched Department of Education's (DOE) responsibility to ensure that public schools do not inappropriately use seclusion and restraint methods and are required, by statute, to develop guidelines for public schools to use in developing seclusion and restraint policies of their own. VOPA has, through the Freedom of Information Act, requested, received and reviewed the policies of several schools and found that many schools do not have policies, even though they do restrain students. VOPA has also reviewed DOE's draft guidelines on the use of seclusion and restraint by public schools and its existing regulations on the use of seclusion and restraint by private schools. Whereas DOE holds private schools to a very high standard – the Human Rights Regulations of the Department of Mental Health, Mental Retardation and Substance Abuse Services, its draft guidelines for public schools are nowhere near as stringent. VOPA will comment on the proposed standards and demand that DOE hold public schools to the same requirements as it does private schools. Also, whenever VOPA receives a case involving school restraint, it reviews the restraint policy of the school to determine whether it is appropriate.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #1: Complete all outstanding non-systemic abuse and neglect investigations pending on October 1, 2003 by March 1, 2004.

For each indicator of success, provide the following information:

a. Focus #5 Objective # 1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 9 pending investigations
d. Target population: PAIMI eligible individuals
e. Outcome: 9 investigations completed

As a result of VOPA's restructuring from grant program-based to task-based units, this objective was established to complete all non-systemic abuse and neglect investigations that were pending on the date of the restructuring. All such pending investigations were completed timely and appropriate remedial action was taken.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #2: Review all Critical Incident Reports submitted by state mental health institutions.

For each indicator of success, provide the following information:

a. Focus #5 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the content of the reports received.
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: All CIR were read and entered into a database

VOPA receives Critical Incident Reports (CIR) submitted by the mental health institutions. Every CIR is read by VOPA staff and pertinent information is entered into a database. All CIR that involve injuries within current program priorities and other alarming or unusual reports are identified and further reviewed. In addition, the VOPA Executive Director conducts a weekly meeting with VOPA staff to address the reports, their implications and remedial action.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #3: Conduct preliminary inquiries of Critical Incident Reports that report a death occurred in a state mental health institution where there is reason to suspect abuse or neglect.

For each indicator of success, provide the following information:

a. Focus #5 Objective #3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the content of the reports received
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: All CIR reporting a death in a state mental health institution were reviewed, and where appropriate, were opened for preliminary inquiry.

One preliminary inquiry involved a death at a state operated mental health facility. The preliminary inquiry revealed indications of abuse and neglect relating to the administration of psychotropic medication, monitoring of the individual while in seclusion and staffing. A full investigation was opened. See narrative at Goal 1, Focus Area 5, Objective 4, paragraph 3, for results of the full investigation.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #4: Conduct a full investigation of two (2) Critical Incident Reports in #3 above where there is probable cause to believe that abuse or neglect occurred and take appropriate action.

For each indicator of success, provide the following information:

a. Focus #5 Objective #4
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 2 investigations
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: systemic reform

Four death investigations have been conducted. Three have been completed with recommendations to the facility.

One investigation revealed significant failure by the facility to conduct essential medical tests and failure to provide needed services by primary care physicians. VOPA found that both failures contributed to a patient's death, caused by gangrene infection, and constituted abuse or neglect. As a result of the investigative findings, VOPA recommended substantial systemic corrective action, including mandatory, annual primary care medical training for facility psychiatrists and mandatory and specific follow-up of abnormal laboratory test results. All recommendations have been accepted by the facility and implemented.

Another investigation uncovered numerous instances of medication without informed consent, inadequate staffing and failure to conduct required monitoring while a patient was secluded. A formal administrative complaint was filed and the facility has agreed to needed systemic reforms.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred

Objective #5: Conduct preliminary inquiries of complaints that report a death in a community setting where there is reason to suspect abuse or neglect.

For each indicator of success, provide the following information:

a. Focus #5 Objective #5
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the number of complaints received
d. Target population: PAIMI eligible individuals living in the community whose death may be related to abuse or neglect.
e. Outcome: Preliminary inquiries of complaints involving death in a community based facility were completed.

Two preliminary inquiries of deaths in community based facilities were completed. One revealed probable cause to believe abuse or neglect occurred and was opened as a full investigation.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #6: Conduct a full investigation of one (1) incident in #5 above where there is probable cause to believe that abuse or neglect occurred and take appropriate action.

For each indicator of success, provide the following information:

a. Focus #5 Objective #6
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 1 investigation
d. Target population: PAIMI eligible individuals living in the community
e. Outcome: Successful completion of investigation resulting in appropriate remedial action

VOPA conducted an investigation of a death in a community based facility and, based on the results of the death investigation and discover of other violations at the facility, a lawsuit seeking injunctive relief was filed. The litigation is pending.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #1: Transition Services for Children Age 14 and Above
Objective #1: Provide legal representation for fifteen (15) children who have been denied transition planning that promotes movement from school to post-school activities.

For each indicator of success, provide the following information:

a. Focus #1 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 5 children
d. Target population: PAIMI eligible children needing transition services
e. Outcome: children's needs were met

As a part of VOPA's representation in transition cases, attorneys examine the role of Disability Service Agencies to ensure that they are fulfilling their obligation to provide transition planning. VOPA has represented over 15 children in transition cases. VOPA has also received complaints and evidence suggesting that the Virginia Department of Rehabilitative Services is not meeting its obligation to provide transition planning or services, including functional behavioral assessments. VOPA served a Notice of Potential Litigation on the Department, informing it of the complaints it received and demanding that the Department fulfill its obligations. In several individual cases, VOPA has demanded that the Department take a more active role. For example, in one case, the Department did not have any client involvement, even though the child was over 16. After VOPA demanded additional involvement by the Department, additional resources were found to provide the child with the services he needed. Settlement negotiations with the Department are ongoing.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #1: Transition Services for Children Age 14 and Above
Objective #2: Represent two (2) residents of juvenile detention facilities whose Individualized Education Program (IEP) contains no transition planning

For each indicator of success, provide the following information:

a. Focus #1 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 2 residents
d. Target population: PAIMI eligible individuals needing transition services who are residing in juvenile detention facilities
e. Outcome: juvenile's needs were met

In one case, VOPA successfully participated in IEP development including an appropriate transition plan.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #2: Children placed in Interim Alternative Educational Placements Due to Disability
Objective #1: Provide legal representation to seven (7) children with disabilities in order to decrease inappropriate placements in interim alternative educational placements. VOPA's representation will focus on securing the provision of appropriate Functional Behavioral Assessments and other procedural due process protections.

For each indicator of success, provide the following information:

a. Focus #2 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 7 children
d. Target population: PAIMI eligible children
e. Outcome: children's needs were met

VOPA has represented 9 children in this area. In one notable case, a school tried to suspend a child for improper behavior. The school argued that the child was not eligible for special education (and therefore was not entitled to a Functional Behavioral Assessment) Because, even though he has bipolar disorder and is failing, he does not meet the requirements of the IDEA. VOPA retained two experts to review the case and prepared a Due Process petition. The investigation is ongoing.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #4: Technical Assistance to Private Bar, Legal Services Agencies, and Parent Advocacy Groups Regarding Changes in the Individuals with Disabilities Education Act (IDEA)
Objective #1: Represent interests of persons with disabilities to the Statewide Special Education Advisory Committee.

For each indicator of success, provide the following information:

a. Focus #4 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: Quarterly meetings
d. Target population: PAIMI eligible children and youth in public schools
e. Outcome: On-going committee awareness of disability rights related to special education

VOPA attends the quarterly meeting of the Statewide Special Education Advisory Committee. This committee is required by the federal government as a first step in federal Continuous Improvement Monitoring Process. Discussions have included Personnel Licensure Issues, completion and submission of the Federal Annual Performance Report, IDEA Reauthorization, State Assessment Update and a State Improvement Grant.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #4: Technical Assistance to Private Bar, Legal Services Agencies, and Parent Advocacy Groups Regarding Changes in the Individuals with Disabilities Education Act (IDEA)
Objective #2: Develop a publication identifying the changes in the Individuals with Disabilities Education Act within 60 days of Congress amending IDEA.
Objective #3: Develop and give three (3) presentations that are tailored to meet the needs of the identified audiences within 30 days of the development of the publication noted in Objective #2.

Objective #4: Inform identified audiences via a mailing of posters and publications, within 60 days of the development of the publication in Objective #2 above, of VOPA's availability to provide training.

For each indicator of success, provide the following information:

a. Focus #4 Objective #2, 3, 4
b. Objective was: Partially Met/Continuing
c. Base Measure used to determine whether priority was met: 60 days from the IDEA amendment
d. Target population: PAIMI eligible individuals in schools
e. Outcome: information, referral, technical assistance and presentations provided

Progress in this area remains limited due to the activities at the Federal government level surrounding IDEA. However, all VOPA staff have continued to provide information and referral, technical assistance, and presentations about IDEA as it stands.

Goal 3: People with Disabilities Have Equal Access to Government Services

Focus Area #1: Law Enforcement Agencies Recognize the Needs of Persons with Disabilities
Objective #1: Identify a program in the southwestern area of Virginia that is focused on law enforcement agencies responding appropriately to persons with mental illness who are in crisis, including persons who are homeless. Support and seek to expand this program.

For each indicator of success, provide the following information:

a. Focus #1 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 1 program
d. Target population: PAIMI eligible individuals in crisis who have contact with law enforcement agencies.
e. Outcome: Task force members have been provided information related to disability rights.

At the request of the VOPA PAIMI Advisory Council, VOPA participates in a task force to bring "Memphis Model" type police training to the Roanoke area of Virginia. VOPA has advised task force members on the law and made itself available for collaboration. The Task Force is made up of advocates, attorneys, health care providers and law enforcement representatives; it is designed to teach police ways to interact with persons with mental illness who are in crisis. The goal is to make arrest a last option, rather than a first. It is hoped that, through the program, police will recognize the needs of people in crisis and help them receive services.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #1: Appropriate Services and Supports to Enable People to Move into the Community
Objective #1: Conduct one (1) patient training at each state mental health institution regarding available community services and how to access the services.

For each indicator of success, provide the following information:

a. Focus #1 Objective # 1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 9 state mental health institutions.
d. Target population: PAIMI eligible individuals living in state mental health institutions
e. Outcome: PAIMI eligible individuals living in state mental health institutions who attended the trainings received information about disability rights specifically related to community services and how to access them.

As part of larger presentations concerning patient rights, VOPA has provided patient trainings at state mental health institutions about available community resources and how to access them. As a direct result of these presentations, VOPA has received requests for services in various areas. Staff report being approached by numerous individuals following presentations with requests for assistance. The typical Technical Assistance that results is providing detailed information regarding the discharge planning process so that the individual is better equipped for self-advocacy or explaining court-ordered treatment or the role of a legally authorized representative.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #1: Appropriate Services and Supports to Enable People to Move into the Community
Objective #2: Identify five (5) unlicensed care facilities for the aged that house persons with disabilities and provide VOPA information.

For each indicator of success, provide the following information:

a. Focus #1 Objective # 2
b. Objective was: Partially Met/Continuing
c. Base Measure used to determine whether priority was met: 5 unlicensed care facilities
d. Target population PAIMI eligible individuals living in unlicensed care facilities
e. Outcome: objective is being continued

VOPA Board members noted this as a significant concern during the public comment period in summer of 2003. VOPA has had difficulty identifying the facilities as they are unlicensed and no single entity monitors/regulates them. In addition, their existence as a "care facility" is difficult to distinguish from simple "housing."

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #1: Appropriate Services and Supports to Enable People to Move into the Community
Objective #3: Investigate process of conducting PASARR (pre-admission screenings) to determine if there is evidence of an institutional bias or other violations of law.

For each indicator of success, provide the following information:

a. Focus #1 Objective #3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: a review was completed
d. Target population: PAIMI eligible individuals living in nursing homes
e. Outcome: VOPA reviewed the PASSR processes and determined that, while there is no inherent institutional bias in the process, the way the screenings are conducted should be monitored.

VOPA conducted a review of the law and procedures surrounding PASARR screenings. VOPA concluded that, while there is no inherent bias in the process, the way the process is conducted may lead to more nursing home placements than necessary. VOPA will monitor nursing home placements to determine whether persons are improperly or inappropriately placed in such facilities and take appropriate action.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #2: Appropriate and Timely Discharge Plans at Mental Health Facilities
Objective #1: Conduct one (1) patient training at each state mental health institution regarding discharge planning rights.

For each indicator of success, provide the following information:

a. Focus #2 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 9 institutions
d. Target population: PAIMI eligible individuals residing in state mental health institutions
e. Outcome: Training participants received information about disability rights

VOPA has provided training for patients regarding discharge planning and has identified persons ready for discharge. Staff report being approached by numerous individuals following presentations with requests for assistance. The typical Technical Assistance that results is providing detailed information regarding the discharge planning process so that the individual is better equipped to for self-advocacy, explaining the role of a legally authorized representative, or court-ordered treatment.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #2: Appropriate and Timely Discharge Plans at Mental Health Facilities
Objective # 2: Identify ten (10) patients of state mental health institutions who remain in such institutions more than 90 days after being found ready for discharge.

For each indicator of success, provide the following information:

a. Focus #2 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 10 patients
d. Target population: PAIMI eligible individuals residing in state mental health institutions.
e. Outcome: individuals' discharge needs were met

VOPA's litigation against the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has resulted in an historic order giving VOPA access to the names and contact information of all those persons with mental illness deemed "ready for discharge" from DMHMRSAS' state mental health institutions. This case was the first in the history of the PAIMI Act to require such access and the first to define "neglect" as the failure to create or implement appropriate discharge plans. As a direct result of VOPA's action, dozens of people have been successfully discharged, some with VOPA's direct action, others through the implementation of appropriate discharge planning. VOPA is contacting people on the "ready for discharge" list and has opened five cases for people who appear on the list (who were not known to VOPA before VOPA received the list). Each person had a discharge plan that should have been, but was not, implemented. In each case, VOPA wrote letters to DMHMRSAS and Community Services Boards demanding the discharge of its client. In each case, DMHMRSAS responded by ensuring the discharge of each person.

VOPA represented a child who was identified as ready for discharge but did not have an appropriate discharge plan. VOPA intervened on her behalf, ensured that a plan was put in place and advocated, successfully, for her discharge. In another case, VOPA represented a person who was found Not Guilty of a misdemeanor by Reason of Insanity. VOPA advocated for his release after 9 years in forensic custody. VOPA worked collaboratively with his criminal attorney to ensure that an appropriate discharge plan was put in place and that the Court accepted it. The person is now living successfully in the community.

After one year in a state mental health institution and several months before that in a private psychiatric facility, VOPA learned of a woman who had been designated Ready-For -Discharge for six months. She expressed significant concerns over the speed of the discharge process. She believed her discharge was delayed due to a lack of effort from her destination Community Services Board (CSB). She stated that the placement facility her discharge plan identified had not changed since her entrance into the state institution although her condition, treatment and community support had changed significantly in the interim. She expressed much frustration over this, and dissatisfaction with her CSB. She also seemed to lack critical information necessary to her involvement in the discharge planning process.

The institution staff stated that the delays in her discharge resulted from her record involving criminal activity and med-noncompliance and she had not agreed to the placement facility. The records indicated that only two facilities had been identified for her placement since her entrance into the state institution. She had visited both facilities several times and continually expressed serious concerns over her future treatment and safety in each facility. It appeared the discharge delay was due to a the lack of communication between the CSB case manager and the client, and a lack of understanding of the client's preferences and concerns on the part of the CSB case manager.

VOPA involvement in this matter consisted of discussion with the CSB, the client and the hospital treatment team regarding their versions of the process to date, and how each understood the final goal. In addition, VOPA contacted the facilities identified in the discharge plan as well as other facilities within the region. VOPA offered an evaluation of the process and suggestions for future action. Within ten days of VOPA's initial involvement, the client achieved discharge and placement in an agreeable facility. She has since left that facility of her own accord and lives independently in the community with the support of her family. She continues to receive treatment and began a new job in September. Here, VOPA identified an issue unknown to the players and served as a conduit of necessary information to significantly speed up the discharge process.

VOPA had an active role in ensuring that persons who have been found incompetent to stand trial are admitted to state mental health institutions rather than kept in jails. VOPA identified several such clients and contacted their attorneys. There has been a decrease in the waiting time for persons to be admitted to mental health institutions from jails. In addition, VOPA represented two persons with mental illness who were found not guilty by reason of insanity of misdemeanors. Both persons should have been released from state mental health institutions but the judges presiding over their cases have refused to do so. VOPA worked in conjunction with their criminal attorneys to ensure that they were released. In one case, VOPA drafted a Motion to require the Judge to allow the person to be released. Prior to the Motion being filed, the individual was discharged to the community.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #3: Appropriate Staffing at State Residential Facilities
Objective #1: In each investigation of abuse and neglect, establish whether staffing may have contributed to the abuse or neglect and take appropriate action

For each indicator of success, provide the following information:

a. Focus #3 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the content of the reports received
d. Target population: PAIMI eligible individuals residing in state mental health institutions
e. Outcome: systemic reform

Staffing is addressed and considered in all state institution investigations. VOPA continues to conduct quarterly trend analyses to determine whether higher incidents of reported injuries are related to staffing levels. In one investigation, VOPA identified significant failures with regard to the qualification of medical personnel to provide appropriate primary care services. The facility has agreed to require that staff psychiatrists receive continuing education in primary care. This systemic reform had the potential to impact a census of about 140 patients.

In another investigation, VOPA found that inadequate staffing procedures for replacement or supplemental nursing staff contributed to abuse or neglect of a patient. A formal administrative complaint was filed and successfully resolved.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #3: Appropriate staffing at State Residential Facilities
Objective #2: Investigate staffing at Eastern State Hospital for compliance with applicable federal requirements. If non-compliance is found, take action to effect change.

For each indicator of success, provide the following information:

a. Focus #3 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: investigation complete
d. Target population: PAIMI eligible individuals residing in state mental health institutions
e. Outcome: systemic reform

VOPA's investigation of a death at Eastern State Hospital revealed numerous instances of abuse and neglect relating to the administration of psychotropic medication, monitoring of the individual while in seclusion, and staffing. VOPA filed a formal complaint and plan for corrective action and conducted the required complaint resolution meeting with the hospital director. The director's final decision and action plan set forth changes that the hospital will make in policy and procedure and a schedule for staff training. VOPA is monitoring compliance with corrective action plan. The hospital has provided training records to document the completion of staff training. This systemic reform favorably affects an average census of 400 patients.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #3: Appropriate staffing at State Residential Facilities
Objective #3: Conduct quarterly trend analyses to determine whether a higher number of incidents of reported injuries are related to staffing levels.

For each indicator of success, provide the following information:

a. Focus #3 Objective #3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: quarterly trend analyses
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: quarterly trend analyses conducted

VOPA conducts quarterly trend analyses of critical incident reports received from state facilities. The trend analyses address a wide variety of potential trends, including type of injury, location of injury, time of day and day of the week, staffing, and other areas. Trend analyses are continuing and are being refined to account for variations, including the number of patients in one institution compared to the number in another institution, and other potential variables to assure accurate comparisons of trends between the various facilities. The VOPA Executive Director conducts a weekly meeting with strategic VOPA staff to discuss and strategize about the reports and their implications. The quarterly trend analyses are planned and conducted per those meetings.

Goal 5: People with Disabilities are Employed to their Maximum Potential

Focus Area #1: Supported employment
Objective #1: Provide legal representation for fifteen (15) persons with disabilities* to ensure that they receive appropriate employment training, as a part of their transition planning from school to post-school activities that meets their abilities, needs, and preferences.

For each indicator of success, provide the following information:

a. Focus #1 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 15 persons with disabilities--this objective was designed to serve persons with any disability; not just PAIMI eligible individuals.
d. Target population: individuals who need appropriate employment training as part of their special education transition services
e. Outcome: clients' needs in this area were met

VOPA has represented persons who complained that the Department of Rehabilitative Services failed to provide adequate transition planning and assistance. VOPA has also acquired and is reviewing contracts between school districts and DRS setting forth each entity's responsibility to provide transition planning. VOPA is currently investigating whether the Disability Service Agencies meet their obligation to take an active role in transition planning. VOPA found that DRS was refusing to provide transition services to eligible children until their last year of high school. After determining that DRS did not provide adequate transition serves, VOPA served a Notice of Potential Litigation on its Commissioner. VOPA demanded that DRS provide transition services to eligible children regardless of their age. Settlement negotiations are ongoing.

Goal 5: People with Disabilities are Employed to their Maximum Potential

Focus Area #1: Supported Employment
Objective #2: Represent ten (10) persons with disabilities who have disputes with the Department of Rehabilitative Services regarding supported employment

For each indicator of success, provide the following information:

a. Focus #1 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 10 persons with disabilities--this objective was designed to serve persons with any disability; not just PAIMI eligible individuals.
d. Target population: individuals having disputes with the Department of Rehabilitative Services about supported employment
e. Outcome: clients' needs were met

VOPA represented over 10 people with disabilities who were denied needed supports and services to gain or maintain employment. In all cases, VOPA advocates for its clients to receive appropriate supported employment services, including vocational rehabilitation and rehabilitation counseling. In one case, VOPA represented a woman with mental illness who was having difficulty working with the Department of Rehabilitative Services to formulate an Individual Plan for Employment. VOPA is working with the client and advocating for her to receive an appropriate IPE.

Goal 6: People with Disabilities have Equal Access to Appropriate and Necessary Health Care

Focus Area #1: Access to Psychiatric Medications in County and Municipal Jails
Objective #1: Represent three (3) inmates in county or municipal jails who have been denied access to needed psychiatric medications.

For each indicator of success, provide the following information:

a. Focus #1 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 3 inmates
d. Target population: PAIMI eligible individuals in county or municipal jails
e. Outcome: clients' needs were met

VOPA has represented four inmates in county or municipal jails who have been denied access to needed psychiatric medications. In one case, an inmate's day-to-day living and potential release were compromised due to the jail's failure to provide medications during the incarceration and failure to provide an adequate supply of such medications after release from custody, placing the inmate at significant risk. VOPA resolved all issues by advocacy and coordination between service providers and law enforcement authorities.

Besides the four open cases, VOPA's advocacy directly resulted in ten additional inmates receiving needed psychiatric medications and services includes, as appropriate, transfer from jail to a state mental health institutions for treatment.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #1: Underserved Communities
Objective #1: By December 2003, identify one (1) additional target population to receive outreach and training

Objective #2: Create training materials and a presentation for the target population by March 31, 2004
Objective 3: Complete mailings and at least two (2) presentation to the target population by September 2004

For each indicator of success, provide the following information:

a. Focus #1 Objective # 1, 2, 3
b. Objective was: Not Met
c. Base Measure used to determine whether priority was met: 1 target population
d. Target population underserved disability population
e. Outcome : Objectives have been revised and continued

The VOPA client database was going to play an integral component in identifying an underserved population. However, VOPA discovered that the database had significant integrity issues. VOPA staff have spent a significant amount of time and effort to develop and implement database enhancements that will help in the identification of underserved populations. These objectives have been carried over to FY2005.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #1: Underserved Communities
Objective #4: Conduct quarterly trainings for McGuire Veterans Administration Medical Center residents.

For each indicator of success, provide the following information:

a. Focus #1 Objective #4
b. Objective was: Met
c. Base Measure used to determine whether priority was met: quarterly trainings
d. Target population: PIAMI eligible individuals residing in McGuire Veterans Administration Medical Center
e. Outcome: patients have received disability rights information

VOPA staff conducted quarterly trainings for patients at the Department of Veterans Affairs McGuire Hospital quarterly. Although the Hospital is aware that VOPA is to provide these trainings due to the Federal Court settlement, routine scheduling of the trainings is an on-going challenge. In addition, free access to the patients is hampered by McGuire staff escorting VOPA staff throughout the wards. The McGuire staff portray a protective, and somewhat paternalistic, approach about the patients in their interactions with VOPA.

Annual staff training has been provided to the McGuire staff about disability rights. The participants have included varying levels staff providers. Future staff trainings will include information on self determination, choice, and informed consent.

Because of the historical settlement VOPA achieved in FY2003 with the Department of Veterans Affairs, there has been nation-wide interest in VOPA's work in this area. The National Association of Protection and Advocacy Systems (NAPAS) faxed a copy of the settlement to every protection and advocacy system legal director. They also noted VOPA's achievement in their newsletter for their Training and Advocacy Support Center (TASC). NAPAS has been in contact with the Department of Veterans Affairs to discuss the possibility of the agency adopting a similar access policy nationwide for protection and advocacy entities. (Please see attachment.)

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #3: Juvenile Detention Facilities
Objective #1: Provide VOPA information to Juvenile Probation Officers and Court Appointed Special Advocates.

For each indicator of success, provide the following information:

a. Focus #2 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 1 mailing
d. Target population: PAIMI eligible individuals served by the Juvenile Probation Officers and Court Appointed Special Advocates
e. Outcome: mailing recipients received information about disability rights

The mailing to juvenile facilities and Court Appointed Special Advocates, including clarification of VOPA's right to access, was completed.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #2: Spanish-Speaking Constituents
Objective #1: Identify five (5) Spanish community contacts in Virginia by December 2003

For each indicator of success, provide the following information:

a. Focus #2 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 5 contacts
d. Target population: PAIMI eligible individuals who speak Spanish
e. Outcome: minority community received information about disability rights

VOPA has partnered with the Governor's Latino Advisory Commission Liaison to develop a planful, strategic outreach effort. VOPA is developing and nurturing a representative committee that reflects the disability and Spanish Speaking communities to help in this area. We have invited representatives from the VOPA Advisory Councils to join us.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #2: Spanish-Speaking Constituents
Objective #2: Develop two (2) VOPA primary publications in Spanish by June 2004

For each indicator of success, provide the following information:

a. Focus #2 Objective #2
b. Objective was: Partially Met/Continuing
c. Base Measure used to determine whether priority was met: 2 publications
d. Target population: PAIMI eligible individuals who speak Spanish
e. Outcome- objective is continuing

VOPA's main publication was revised this year (it was included in the PAIMI application). This publication was translated into Spanish using a software package. To ensure that the translation had retained the intent and tone of the English version, VOPA had person who speaks Spanish review it. It was then shared with VOPA's Spanish Speaking Outreach Committee who are recommending even further edits.

VOPA intended to translate its poster into Spanish. However, public comment this year has alerted us that many people cannot distinguish the difference between VOPA and the DMHMRSAS Human Rights poster. DMHMRSAS' poster is currently under revision. Once they complete their poster, VOPA will review our poster for revision/translation.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #2: Spanish-Speaking Constituents
Objective #3: Complete two (2) presentations or training sessions between June 2004 and September 2004 for Spanish communities.

For each indicator of success, provide the following information:

a. Focus #2 Objective #3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 2 presentations
d. Target population: PAIMI eligible individuals who speak Spanish
e. Outcome: minority community received information about disability rights

A presentation was provided to the Governor's Latino Advisory Commission about VOPA and disability rights. Based on feedback from the Commission, VOPA has re-evaluated and revised its outreach plan for this population. At the first meeting of the potential Spanish Speaking Outreach committee, a discussion about VOPA's mission and disability rights was conducted.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #3: Adult Care Homes (Assisted Living Facilities)
Objective #1: Inform operators and residents of VOPA's mission and availability by completing a mailing of VOPA posters and materials by December 2003.

For each indicator of success, provide the following information:

a. Focus #3 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 1 mailing to 56 providers
d. Target population: PAIMI eligible residents of adult care homes/assisted living facilities
e. Outcome: mailing targeted population received information about disability rights

A mailing list targeting Virginia Department of Social Services licensed assisted living facilities in southwest Virginia was completed. This mailing including VOPA brochures, posters and a cover letter informing them of VOPA's mission and availability.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #3: Adult Care Homes (Assisted Living Facilities)
Objective #2: Inform operators of VOPA's availability to provide training in the area of disability rights through random monthly drop-in visits.

For each indicator of success, provide the following information:

a. Focus #3 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 12 drop in visits
d. Target population: PAIMI eligible residents of adult care homes/assisted living facilities
e. Outcome: Adult Care Homes monitored received information about disability rights

VOPA has developed a monitoring protocol for drop-in visits to Adult Care Homes. Feedback is provided to the Adult Care Homes about their efforts to protect disability rights.

D. OTHER COMMENTS CONCERNING PAIMI SYSTEM OPERATIONS:

Over the past year, VOPA Board, Councils and staff have made a significant effort to enhance the public's knowledge of VOPA's mission and efforts. Through the Councils, Spanish outreach committee and focus groups, the public awareness of VOPA and its role is becoming more clear to Virginians with disabilities and their advocates.